

HOUSTON INDEPENDENT SCHOOL DISTRICT
Office of Special Education Services
Child Study Department

REQUEST FOR REEVALUATION
Information from Parents

Student: _____ Age: _____ Sex: _____ Birthdate: _____
 School: _____ Grade: _____ Social Security Number: _____
 Parent's Name: _____ Home Phone: _____
 Home Address: _____ Zip: _____

☐ ☐ Student's parents have been contacted. Method of contact: ☐ LETTER ☐ TELEPHONE ☐ CONFERENCE
 YES NO

Contacted by: _____ Position: _____ Date: _____

The following information was obtained from: _____

GENERAL INFORMATION

_____ Father's Name _____ Occupation/Place of Employment _____ Work Phone _____

_____ Mother's Name _____ Occupation/Place of Employment _____ Work Phone _____

Who has legal authority to make educational decisions for this child? _____

Do both parents live in the student's home? ☐ YES ☐ NO If NO, with whom does the child live? _____

OTHER CHILDREN AND ADULTS IN THE HOME

Name	Age	Relationship	Name	Age	Relationship
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Language spoken at home: _____ Language usually spoken by the child: _____

☐ YES ☐ NO Have there been any important changes within the family during the last three years?

☐ Family move YES _____ NO _____ Recent move _____

☐ Changed schools List previous schools he/she attended? _____

☐ Births, Deaths, Illnesses (Please explain: _____)

☐ Separation/Divorce (When? _____)

☐ Other: _____

STUDENT INFORMATION

1. What does your child like to do? _____

2. Does anything seem hard for your child to do? ☐ YES ☐ NO If YES, please explain: _____

3. Does your child have problems with school work? ☐ YES ☐ NO If YES, please explain: _____
4. Are you worried about your child's behavior at school or at home? ☐ YES ☐ NO If YES, please explain: _____
5. What does your child do when not in school? (For example, watch TV, read, part-time job, play with other children.) _____
6. What activities does the family do together? (For example, watch TV, go camping, and/or participate in hobbies or sports.) _____
7. Which of the following do you use to discipline your child?
- | | | | |
|------------------------------------|-------------------------------------|--|---|
| <input type="radio"/> Spanking | <input type="radio"/> Extra chores | <input type="radio"/> Time Out | <input type="radio"/> Take away privileges |
| <input type="radio"/> Grounding | <input type="radio"/> Early Bedtime | <input type="radio"/> Extra privileges | <input type="radio"/> Rewards for good behavior |
| <input type="radio"/> Other: _____ | | | |
- Do these methods of discipline seem to work? ☐ YES ☐ NO
8. Describe your child's behavior at home/in the neighborhood:
- | | | |
|--|---|---|
| <input type="radio"/> generally well-behaved | <input type="radio"/> gets along well with family members | <input type="radio"/> minds well |
| <input type="radio"/> appears happy | <input type="radio"/> plays well with neighborhood children | <input type="radio"/> has nightmares |
| <input type="radio"/> is overactive | <input type="radio"/> is hostile/aggressive towards others | <input type="radio"/> seems anxious/upset |
| <input type="radio"/> wets the bed | <input type="radio"/> accepts responsibility for chores | <input type="radio"/> is shy |
| <input type="radio"/> seems unhappy/withdrawn/depressed | | <input type="radio"/> is defiant |
| <input type="radio"/> participates in organized group activities (sports, scouts, church groups, etc.) | | |
9. Has his/her behavior changed in the last few years? ☐ YES ☐ NO If YES, please explain: _____
10. How does your child feel about school? _____
11. What else would you like us to know about your child? _____

CURRENT SPECIAL EDUCATION SERVICES

How does the school report to you about your child's progress?

<input type="radio"/> Report Card	<input type="radio"/> Written Progress Report
<input type="radio"/> Updated copy of IEP	<input type="radio"/> Verbal Report
<input type="radio"/> Other: _____	

COMMENTS: _____

HEALTH HISTORY

1. Has your child had any serious illnesses, been in any accidents, or been hospitalized in the last three years? ☐ YES ☐ NO
If YES, please describe the illness, accident, or reason for hospitalization and give your child's age at the time. _____
2. What time does your child go to bed at night? Does he/she have trouble sleeping? ☐ YES ☐ NO If YES, please describe: _____

YES	NO	
<input type="radio"/>	<input type="radio"/>	Is your child under care of a doctor for a medical condition? If YES, please explain: _____ Name of doctor: _____
<input type="radio"/>	<input type="radio"/>	Does your child appear to have any other physical health conditions, including allergies? If YES, please explain: _____
<input type="radio"/>	<input type="radio"/>	Has your child ever taken medicine for a long period of time? If YES please explain: _____
<input type="radio"/>	<input type="radio"/>	Is your child now taking any medications? If YES, please identify the medicine and what it is for: _____
<input type="radio"/>	<input type="radio"/>	Are there any family health concerns you would like us to be aware of? If YES, please explain: _____
<input type="radio"/>	<input type="radio"/>	Is your child receiving services from another agency? If YES, please explain: _____

Signature of Parent

DATE: _____

Signature of Interviewer and Title (if obtained by parent interview)

DATE: _____